Doctor of Nursing Practice Program
The Graduate School
College of Nursing

Verification of Post-BSN Clinical and Practice Hours

Instructions:
The DNP applicant should upload the completed form to his or her application in NursingCAS.

Student Name (Print or type):____
First Middle/Maiden Last

Student SS or School ID Number:____

The information below must be completed by the program director:

1. Name of University:____

   Program Name:____

   University Address:____

   University Telephone:____

2. Type of Degree Received:
   ____Masters of Science in Nursing Program
   ____Post Master's Certificate Program

3. Area of Concentration:____

4. Date of Program Completion:____

5. Total number of clinical practice hours in the program (clock hours):____________________

6. Your signature on this form attests that the above named individual has completed the program indicated on this document.

   Program Director (print name):____

   Program Director (signature):____

   Date:____

Augusta University
Doctor of Nursing Practice Program
Phone: 706.721.3676

Augusta University
Office of Admissions,
1120 15th Street
Benet House
Augusta, GA, 30912

Last Updated: 8.9.2016